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V. Payment Assurance

As a condition of participation, when signing the provider agreement, the provider agrees to accept, as payment in full, the rate paid by the State agency in accordance with the reimbursement formula detailed above.

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VI. Notice of Limits to be Imposed

Each provider shall receive a notice of the methods to be imposed at least 30 days prior to the date under which that provider shall receive reimbursement under this plan.

The state agency will give public notice of any significant proposed change in methods and standards for setting payment rates for services, in compliance with the conditions established by 42 CFR 447.205.

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VII. Exception Procedure

A Class I, II, or III provider may file with the State agency a petition for emergency relief, either at the time of the emergency by filing an interim rate certification or at the time of submission of the cost report covering the time period of the emergency. For purposes of this section, an emergency exists when the lives, well being, or continuation of care of Medicaid recipients is placed in jeopardy. Emergency relief may be granted if the provider can show to the satisfaction of the State agency that a change in law or regulation, a fire or natural disaster, with a substantial effect on operating costs caused the emergency for which the relief is requested.

Emergency relief shall consist of a rate add-on based on the expected added cost of the change. The rate add-on shall be determined from a cost certification form submitted by the provider and shall be subject to approval by the single State agency pending unit.

Emergency relief will require a retrospective cost settlement of the provider's cost reporting period(s) commencing with the period for which the emergency relief was filed and continuing until such time as the provider's cost data base appropriately reflects the cost of the operational changes for which relief was given. Rebasing of the provider's prospective rate will occur when this costs data base is available. The cost settlement shall be made utilizing the principles and guidelines stated in Sections I, II, and III above and shall not exceed the appropriate cost limitations in Section IV above. In addition, if applicable, a retrospective profit factor may be added to the rate based on the principles outlined in Sections IV.B.3. Also, if applicable, a retroactive adjustment to the incentive component may be added to the rate based on the principles outlined in Section IV.D. To determine allowable per patient day variable costs for the latter adjustment, the principles and definitions contained in Section IV.C.Q. & 2. apply.

If, upon audit, the agency finds a discrepancy between certified information and actual costs, all excess funds paid by the State to the facility as a result of that certification will be recovered with a penalty factor (equal to the then current Medicare rate on net invested equity) applied to the discrepancy.

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VIII. Appeals Procedure

The appeals procedure consists of an informal review which can be initiated by a provider upon receipt of a notice of adverse action, or as provided for under Section IV.A.4.b.1) and Section IV.C.4., and a formal hearing which can be initiated by a provider upon receipt of a notice of an adverse action or a final determination notice. Procedure I contains provisions for: 1) all classes of providers for formal hearings; 2) all classes of providers for informal reviews which pertain to such adverse action issues as cost settlement and rate determinations, and incentives; and 3) Class IV and V providers for informal reviews of audit findings, if applicable. Procedure II contains provisions for the informal review of an adverse action that is contained in the final summary of audit findings issued by the State agency. This procedure is available to Class I, II, and III providers and is effective for cost reporting periods ending on or after September 30, 1987.

A. Procedure I

1. Once a notice of adverse action is issued, a provider may invoke Procedure I by submitting its application in writing to the State agency. The written request shall include an identification of the issue(s) for which resolution is being sought and a description of why the provider believes the determination on these matters is incorrect.

   For the purposes of Section IV.A.4.b.1, adverse action will constitute the period from January 1, 1991 to the start of the provider's first fiscal year after April 1, 1991. For purposes of Section IV.C.4,, adverse action will constitute the period from the start of the provider's fiscal year to 45 days following notification by the state agency of the prospective reimbursement rate.

2. Appeals which are allowable under this plan through this procedure will be conducted in accordance with the procedures outlined in the rules, filed on March 4, 1978, as amended, and adopted into Administrative Rules, R400.3401 through R400.3424.

3. A written application for a formal hearing (that is, a hearing conducted by an administrative law judge) must be received within 45 calendar days of the date of notice of an adverse action or a final determination notice. Exceptions: 1) A written request for a formal hearing pertaining to a notification of intent to terminate shall be made in accordance with subrule 6(4) of Administrative Rule R400.3406. 2) A written application for a formal hearing following an administration conference conducted under Provision 4(c) of Procedure II shall be made in accordance with Provision 4(e) of Procedure II. and 3) As otherwise provided in Section VIII.A.1. above

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B. Procedure II--Provisions for Audit Reviews & Appeals

At the election of the provider, Department of Social Services' Medicaid Provider Reviews and Hearing Rules R400.3402 through R400.3403 will not apply to provider appeals of audit findings initiated by Class I, Class II, and Class III providers of long term care for cost reporting periods ending on or after September 30, 1987. In place of these rules, the following provisions will apply.

1. Provision 1. As used in these provisions:

(a) "Adverse action" means the audit adjustments contained in the final summary of audit findings that is issued by the appropriate audit representative(s) of the department.

(b) "Administration" means the medical services administration of the Michigan department of social services.

(c) "Administration director" means the director of the medical services administration, Michigan department of social services.

(d) "Appropriate audit representative(s)" means that individual(s) employed by or contracted by the Michigan department of social services to conduct audits of provider cost reports.

(e) "Days" as used herein refers exclusively to calendar days unless otherwise specified.

(f) "Delegate" means a person who is authorized to act on behalf of the administration director.

(g) "Department" means the Michigan department of social services, its officials, or agents.

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(h) "Director" means the director of the Michigan department of social services.

(i) "Final determination notice" means a notice of an adverse action which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule, or guideline under which the action is taken; and the right to a hearing.

(j) "Provider" means an individual, firm, corporation, association, agency, institution, or other legal entity which is providing, has formerly provided, or has been approved to provide, medical assistance to a recipient pursuant to the medical assistance program.

(k) "Receipt of . . ." as used herein is either on the day of personal delivery or will be presumed on the third day subsequent to the postmark date if the article of mail containing the referenced document is: deposited in Michigan in the United States mail; mailed first class; and properly addressed with postage prepaid.

2. Provision 2. The provider must prepare a correct, complete cost report and assure that this cost report is received by the appropriate organizational entity in the administration within 90 days of the date of its fiscal year end.

3. Provision 3. Audit review process:

(a) The appropriate audit representative(s) must complete his field (desk) audit and issue a preliminary summary of audit findings to the provider within 135 days of the date of receipt of the correct, complete cost report.

(b) If the provider or its representative desires to contest the findings required by Provision 3(a), the provider or its representative must respond to the appropriate audit representative(s) within 10 days of the receipt of the preliminary summary of audit findings, and indicate which findings it contests.

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(c) If no timely request for an area office conference is made by a provider or its representative, the audited data as outlined in the preliminary summary of audit findings will be submitted for the rate determination process mentioned in Provision 4(d). The provider will be deemed to have waived its right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The findings as outlined in the preliminary summary of audit findings will be implemented.

(d) The appropriate audit representative(s) must, within 10 days of receipt of the response referenced in Provision 3(b), schedule and conduct a conference to discuss the preliminary summary of audit findings. This conference will be called the area office conference. The provider or its representative must present the appropriate audit representative(s) with the documents and arguments it feels supports its position relative to the issue(s) it is contesting. Likewise, the appropriate audit representative(s) shall explain to the provider his/her basis for the findings which the provider is contesting.

(e) The appropriate audit representative(s) must, within 15 days of the date of the area office conference, issue a final summary of audit findings to the provider. This is the final step in the audit review process.

(f) If no timely request for an administration conference is made by a provider or its representative, the audited data as outlined in the final summary of audit findings will be submitted for the rate determination process mentioned in Provision 4(d). The provider will be deemed to have waived its right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The findings as outlined in the final summary of audit findings will be implemented.

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4. Provision 4. Appeal process - administration conference:

(a) If the provider desires to appeal items contained in the final summary of audit findings it must file, within 10 days from the date of receipt of the final summary of audit findings, a request with appropriate delegate of the medical services administration. The request must detail each item in the final summary of audit findings that the provider wishes to appeal.

(b) The provider or its representative(s) cannot appeal field (desk) audit findings at the administration conference that it did not contest during the area office conference.

(c) Upon receipt of the provider's request as detailed in Provision 4(a) above, the delegate of the medical services administration must schedule an administration conference. The delegate must schedule and conduct the conference, and the medical services administration must issue its report of the conference and a final determination notice (pursuant to Provision 1(i) and Rule 5 (R400.3405) of the department's rules for Medicaid provider reviews and hearings) within 45 days from the date of the provider's request as filed in accordance with Provision 4(a) above.

(d) Within 20 days from the date of the final determination notice issued by the director of the medical services administration, the bureau of medicaid fiscal review's long term care cost settlement section will be required to issue the provider a prospective rate based upon the audited cost data as amended, if necessary, by the findings of the administration conference.

(e) Within 15 days of receipt of the final determination notice, the provider or its representative(s) may request a formal hearing before an administrative law judge. The formal hearing will be conducted in accordance with the Michigan department of social services' medicaid provider reviews and hearings rules, R400.3401 and R400.3406 through R400.3424.

(f) If no timely request for an administrative hearing is made by a provider or its representative(s), the provider will be deemed to have waived its rights to an administrative hearing. No further administrative appeal rights will be afforded the provider under these provisions. The action as outlined in the final determination notice will be implemented.

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5. Provision 5. In computing any period of time prescribed or allowed, the day of the act, event, or default after which the designated period of time begins to run is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until 5 p.m. of the next business day which is neither a Saturday, Sunday, nor legal holiday.

C. Specific Situation Provisions for Procedure II

1. If the cost report of a provider is not filed timely (that is, in accordance with Provision 2), the State agency will have the option to distribute "late days" into any segment of the time frame for which the State agency is the responsible entity. For this purpose, "late days" mean the number of calendar days that have elapsed from the day after the cost report was due through the day the cost report is accepted by the State agency as being correct and complete. The State agency will notify the provider of the date of acceptance, the number of late days the State agency has available for distribution, and the number of these days, if any, the State agency has chosen to distribute to the audit process.

2. If the cost report of a provider is not correct or complete, the "clock" for the audit segment of the cycle (that is, the process that is conducted in accordance with Provision 3(a)) will be stopped. The clock will be set for recommencement of the 135 day period on the day the resubmitted cost report is accepted by the State agency as being correct and complete. The State agency will notify the provider of the date of acceptance.

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3. If the State agency is responsible for a delay in the procedures AND either an area office conference or administration conference is in progress, or the potential for an area office conference or an administration conference is still open, at the beginning of the rate year that begins a year and a day after the end of the fiscal year that is being processed the provider will be given a provisional rate for the new rate year. For this purpose, "delay in the procedures" means, if applicable: 1) the State agency failed to issue the preliminary summary of audit adjustments timely (that is, in accordance with Provision 3(a) or as amended in accordance with specific situation 1); 2) the State agency failed to conduct the area office conference timely (that is, in accordance with Provision 3(d) or as amended pursuant to specific situation 1); 3) the State agency failed to issue the final summary of audit findings timely (that is, in accordance with Provision 3(e) or as amended pursuant to specific situation 1); and/or 4) the State agency failed to issue a final determination notice timely (that is, in accordance with Provision 4(c) or as amended pursuant to specific situation 1). The provisional rate will be established by updating the payment rate for the immediately preceding rate year with an appropriate nursing home cost factor adjustment for the new rate year. Upon the completion of the audit appeal process, an adjustment, retroactive to the beginning of the new rate year, will be made.

D. Nonappealable Elements

Elements of the reimbursement program for which an administrative remedy, if permitted for a single provider, would imply or necessitate a change in the program for all providers or for all providers in a class may not be appealed through administrative rules or provisions but may be appealed to a court of appropriate jurisdiction. These elements include, but are not limited to: 1) the formula for the determination of the inflationary adjustors (Section IV.C.3.; 2) the principles of reimbursement and guidelines which define allowable costs (Section III.); 3) non-Medical Assistance Program issues; 4) the cost limits, unless otherwise specifically provided (Sections IV.B.2., and the appropriate subsections of IV.C.3. and IV.B.4.); and 5) the State agency determination of the allowability of items certified under this plan (until such time as an audit is completed).